Appendix 19
Wisconsin Medicaid
Nurse Aide Training and Competency Evaluation
Reimbursement Request Instructions

Use these instructions to complete the Nurse's Aide Training and Competency Evaluation Reimbursement Request form. Reimbursement requests are denied if the following information is not provided.

Provider Name
Enter the name of the facility employing the nurse's aide.

Wisconsin Medicaid Provider Number
Enter the eight-digit provider number of the facility providing the training or competency evaluation.

The following information must be provided for <u>each</u> nurse's aide receiving training or a competency evaluation.

Aide's Last Name
Enter the last name of the nurse's aide receiving training or a competency evaluation.

Aide's First Name
Enter the first name of the nurse's aide receiving training or a competency evaluation.

Hire Date
Enter the date (in MMDDYY format) the nurse's aide was hired by the facility billing for the training or competency evaluation.

Social Security Number
Enter the nine-digit Social Security number of the nurse's aide receiving training or a competency evaluation.

Competency Evaluation
Check this element if the nurse's aide received a competency evaluation. Only check the "new aide training" element *and* the "competency evaluation" element when the nurse's aide received *both* training and a competency evaluation.

Date of Evaluation
Enter the date (in MMDDYY format) of the competency evaluation. Only indicate a date in "date of new aide training" *and* this element when the nurse's aide received *both* training and a competency evaluation.

New Aide Training
Check this element if the nurse's aide received new aide training. Only check the "new aide training" element *and* the "competency evaluation" element when the nurse's aide received *both* training and a competency evaluation.

Date of New Aide Training
Enter the last date (in MMDDYY format) of the new aide training. Only indicate a date in "date of evaluation" *and* this element when the nurse's aide received *both* training and a competency evaluation.

Signature/Date
An authorized representative of the facility must sign and date the Reimbursement Request form.

Send completed forms to:

EDS
6406 Bridge Road
Madison, WI 53784-0002